NOAA 56-58
(6-03)

NOAA DIVING MEDICAL HISTORY REPORT

NOTE: COMMISSIONED OFFICERS AND WAGE MARINE EMPLOYEES MAY NOT USE THIS FORM, MUST use forms SF-88 & SF-93 and MUST follow NMAO medical exam guidelines IN ADDITION TO NDC guidelines. Contact NMAO Health Services about required testing for initial and periodic physicals.

1. NAME (Last, First M.I.)		2. SOCIAL SECURITY NUMBER	3. DATE OF EXAM
4. AGENCY	5. DIVING UNIT		6. WORK PHONE
7. DATE OF BIRTH	8. AGE	9. SEX ☐ MALE ☐ FEMALE	10. WORK ADDRESS
11. CURRENT MEDICATION & DOSAGE			12. NAME OF EXAMINING FACILITY OR EXAMINER, AND ADDRESS
13. PRESENT HEALTH			
14. ALLERGIES (List All)			15. RATING OR SPECIALTY OF EXAMINER

16. PAST/CURRENT MEDICAL HISTORY *(Do you have or have you ever had the following)*

CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO	CHECK EACH ITEM	YES	NO
Trouble with your ears, including ruptured ear drum, difficulty clearing your ears, or surgery			Heart disease or high cholesterol			Surgery of any kind (if yes, explain below)		
			Diabetes mellitus			Hospitalization for any reason (if yes, explain below)		
Decompression sickness, embolism, or other diving malady			Anatomical heart abnormalities including patent foramen ovale, valve problems, etc					
						Take any medications (list above)		
Depression, anxiety, claustrophobia, or any other psychiatric disorder			Heart rhythm problems			Allergic to any medications, foods, or environmental factors (list above)		
			Need for a pacemaker					
Eye surgery			Difficulty with exercise			Smoke (if yes, how much)		
Loss of consciousness for any cause			High blood pressure			Drink alcoholic beverages (how much)		
Epilepsy, or other seizures, convulsions, or fits			Collapsed lung			Family history of high cholesterol		
Stroke or any neurological deficit			Asthma			Family history of heart disease or stroke		
Recurring neurologic disorders, including transient ischemic attacks			Exposed to a person with tuberculosis (TB), or have persistent cough, sweats, or weight loss			Family history of diabetes		
						Family history of asthma		
Aneurysms or bleeding in the brain			Tuberculosis or positive TB test			Substance abuse, including alcohol		
Trouble with dizziness			Other lung diseases			Use any illegal substances		
Head injury			Pregnancy			Thyroid trouble		
Disorders of the blood or easy bleeding			Date of last menstrual period:			Bone, joint, or other deformity		

17. EXPLAIN IN DETAIL "YES" ANSWERS TO ANY OF THE ABOVE QUESTIONS

I certify that the above answers and information represent a true, accurate, and complete description of my medical history.

18. TYPED OR PRINTED NAME OF PATIENT	19. SIGNATURE	20. DATE

21. EXAMINER SUMMARY OF DEFECTS

22. TYPED OR PRINTED NAME OF EXAMINER	23. SIGNATURE	24. DATE